		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039800

Facility Name: Casey Care Center

Address: 5 Doctors Park (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-1064 **Fax #** (618) 242-7559

IDPA ID Number: 391516877001

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,690	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,600	6,424		25,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,600	6,424		25,024	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.68%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	104,180	9,723	5,166	119,069		119,069		119,069			1
2	Food Purchase		103,638		103,638		103,638	(15,584)	88,054			2
3	Housekeeping	74,292	11,408		85,700		85,700		85,700			3
4	Laundry	32,027	9,595		41,622		41,622		41,622			4
5	Heat and Other Utilities			61,315	61,315		61,315		61,315			5
6	Maintenance	15,786		26,827	42,613		42,613		42,613			6
7	Other (specify):*											7
8	**TOTAL General Services**	226,285	134,364	93,308	453,957		453,957	(15,584)	438,373			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	886,838	36,374	654	923,866		923,866	50	923,916			10
10a	Therapy			176	176		176		176			10a
11	Activities	18,794	5,342	2,513	26,649		26,649		26,649			11
12	Social Services	16,422	138	763	17,323		17,323		17,323			12
13	Nurse Aide Training											13
14	Program Transportation			658	658		658		658			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	922,054	41,854	10,764	974,672		974,672	50	974,722			16
	C. General Administration											
17	Administrative	48,299		123,000	171,299		171,299		171,299			17
18	Directors Fees											18
19	Professional Services			1,541	1,541		1,541	30,356	31,897			19
20	Dues, Fees, Subscriptions & Promotions			4,384	4,384		4,384	63	4,447			20
21	Clerical & General Office Expenses	20,615	3,695	21,294	45,604		45,604	3,423	49,027			21
22	Employee Benefits & Payroll Taxes			123,976	123,976		123,976	63,554	187,530			22
23	Inservice Training & Education			187	187		187		187			23
24	Travel and Seminar			869	869		869	566	1,435			24
25	Other Admin. Staff Transportation			148	148		148		148			25
26	Insurance-Prop.Liab.Malpractice			42	42		42	60,515	60,557			26
27	Other (specify):*											27
28	**TOTAL General Administration**	68,914	3,695	275,441	348,050		348,050	158,477	506,527			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,217,253	179,913	379,513	1,776,679		1,776,679	142,943	1,919,622			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Casey Care Center #0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			9,613	9,613		9,613	122,558	132,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,107	2,107		2,107	284,008	286,115			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			424,902	424,902		424,902	(424,902)				34
35	Rent-Equipment & Vehicles			2,525	2,525		2,525		2,525			35
36	Other (specify):* Mtge. Insurance							4,039	4,039			36
37	TOTAL Ownership			439,147	439,147		439,147	(14,297)	424,850			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			75	75		75		75			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* Nonallowable Costs			17,171	17,171		17,171	(17,171)				43
44	TOTAL Special Cost Centers			75,281	75,281		75,281	(17,171)	58,110			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,217,253	179,913	893,941	2,291,107		2,291,107	111,475	2,402,582			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(525)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,327	30		9
10	Interest and Other Investment Income	(430)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,253)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,355)	43		18
19	Entertainment				19
20	Contributions	(375)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,053)	43		24
25	Fund Raising, Advertising and Promotional	(710)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,868)	43		28
29	Other-Attach Schedule See attached Schedule 5A	(646)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (28,888)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	140,363		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 140,363		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 111,475		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center

ID# 0039800

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Casey Care Center
Provider #0039800
June 30, 2003

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Description	Amount	Line
Nonallowable collection fees	(296)	19
Miscellaneous income offset	(350)	21
Total	(646)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	50	0	0	0	0	0	0	0	0	0	50	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	50	0	0	0	0	0	0	0	0	0	50	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,549	10,103	0	0	0	0	0	0	0	0	30,652	19
20	Fees, Subscriptions & Promotions	0	9	54	0	0	0	0	0	0	0	0	63	20
21	Clerical & General Office Expenses	0	3,773	0	0	0	0	0	0	0	0	0	3,773	21
22	Employee Benefits & Payroll Taxes	0	47,970	0	0	0	0	0	0	0	0	0	47,970	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	566	0	0	0	0	0	0	0	0	0	566	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	37,370	23,145	0	0	0	0	0	0	0	0	60,515	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	110,237	33,302	0	0	0	0	0	0	0	0	143,539	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	110,287	33,302	0	0	0	0	0	0	0	0	143,589	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Casey Care Center # 0039800 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,327	0	116,231	0	0	0	0	0	0	0	0	122,558	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,683)	146	286,545	0	0	0	0	0	0	0	0	284,008	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(424,902)	0	0	0	0	0	0	0	0	(424,902)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	4,039	0	0	0	0	0	0	0	0	4,039	36
37	**TOTAL Ownership**	3,644	146	(18,087)	0	0	0	0	0	0	0	0	(14,297)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(31,886)	0	14,715	0	0	0	0	0	0	0	0	(17,171)	43
44	**TOTAL Special Cost Centers**	(31,886)	0	14,715	0	0	0	0	0	0	0	0	(17,171)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,242)	110,433	29,930	0	0	0	0	0	0	0	0	112,121	45

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc.	100.00%	Mt. Vernon Care Center	Mt. Vernon	Caravilla Charitable		
		Jeffersonian Care Center	Mt. Vernon	Corporation	Mt. Vernon	Lessor
Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions						
with the nursing home during the reporting period.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing supplies	$	Caravilla Resident Centers, Inc.	100.00%	$ 50	$ 50	1
2	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	20,549	20,549	2
3	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	9	9	3
4	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	3,773	3,773	4
5	V	22	Emp. Benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	47,970	47,970	5
6	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	566	566	6
7	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	37,370	37,370	7
8	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	146	146	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 110,433	$ * 110,433	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 10,103	$ 10,103	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	54	54	16
17	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	23,145	23,145	17
18	V	30	Depreciation		Caravilla Charitable Corporation	**	116,231	116,231	18
19	V	32	Interest expense		Caravilla Charitable Corporation	**	286,545	286,545	19
20	V	34	Rent expense	424,902	Caravilla Charitable Corporation	**		(424,902)	20
21	V	36	MIP - Insurance		Caravilla Charitable Corporation	**	4,039	4,039	21
22	V	43	Penalties		Caravilla Charitable Corporation	**	14,715	14,715	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V				**Caravilla Charitable Corporation and Caravilla				27
28	V				Resident Centers, Inc. have the same board of directors.				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 424,902			$ 454,832	$ * 29,930	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	None	2 hrs/mtg.		None	$ 0		1
2	Roger Ryan	Vice President	Board Member	None	None	2 hrs/mtg.		None	0		2
3	William Armstrong	Treasurer	Board Member	None	None	2 hrs/mtg.		None	0		3
4	Kay Baker	Secretary	Board Member	None	None	2 hrs/mtg.		None	0		4
5	Ronald O'Daniell	Director	Board Member	None	None	2 hrs/mtg.		None	0		5
6	Merla McCloud	Recorder	Administrative	None	None	2 hrs/mtg.		None	0		6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 2020 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-9596

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing supplies	Number of beds	235	3	$ 110	$	106	$ 50	1
2	19	Professional fees	Number of beds	235	3	45,556		106	20,549	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	19		106	9	3
4	21	Office supplies & telephone	Number of beds	235	3	8,520		106	3,773	4
5	24	Travel & seminar	Number of beds	235	3	1,036		106	566	5
6	32	Interest expense	Number of beds	235	3	312		106	146	6
7										7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						47,970	10
11	26	Vehicle, fire & liab. insurance	Direct method						37,370	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 55,553	$		$ 110,433	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NCS Healthcare, Inc.		x	Hardware/Software	$728.00	10/31/98	$ 29,136	$ 6,380	01/01/04	0.1429	$	1
2	Continental Wingate		x	Purchase Facility	$55,560.00	09/16/96	7,402,500	3,236,431	10/01/31	0.0855	276,555	2
3												3
4												4
5							Amortization expense				4,291	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,288.00		$ 7,431,636	$ 3,242,811			$ 280,846	9
	B. Non-Facility Related*											
10								Finance charges			2,253	10
11								Offset on interest income			(430)	11
12								Non-allowable finance charges			(2,253)	12
13								Parent company allocation			5,699	13
14	TOTAL Non-Facility Related						$	$			$ 5,269	14
15	TOTALS (line 9+line14)						$ 7,431,636	$ 3,242,811			$ 286,115	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 4,039 **Line #** 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039800

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	120,000	1994	$ 110,000	1
2					2
3	TOTALS	120,000		$ 110,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1994	1970	$ 2,025,900	$	40	$ 50,648	$ 50,648	$ 443,169	4
5			1998	1998	6,585		40	165	165	907	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	2,586		15	172	172	1,456	9
10	4 doors			1995	715		15	48	48	336	10
11	3 furnaces, 2 a/c's, 3 coils			1995	14,366		15	958	958	6,706	11
12	Windows			1996	20,184		15	1,346	1,346	8,581	12
13	Fire & security alarms			1996	9,560		15	637	637	4,061	13
14	Architecture costs			1996	7,939		15	529	529	3,372	14
15	Asphalt & sidewalk			1996	7,408		15	500	500	3,149	15
16	Roofing			1996	54,022		15	3,601	3,601	22,957	16
17	Fire & security alarm			1997	4,110		15	274	274	1,747	17
18	Paint & wallpaper			1997	3,082		15	205	205	1,308	18
19	Hinges & doors			1997	6,284		15	419	419	2,671	19
20	Tile			1997	10,739		15	716	716	4,564	20
21	Garage & ground prep			1997	10,489		15	699	699	4,456	21
22	Roofing			1997	7,202		15	480	480	3,060	22
23	Handrail			1997	10,900		15	727	727	4,635	23
24	HVAC			1997	27,483		15	1,833	1,833	11,684	24
25	Dryvit			1997	13,900		15	927	927	5,910	25
26	Plumbing & electrical			1997	21,742		15	1,449	1,449	9,238	26
27	Architecture costs			1997	1,986		15	132	132	842	27
28	Flooring			1997	700		15	47	47	258	28
29	Remodeling of facility			1997	18,980		15	1,265	1,265	6,958	29
30	A/C Timer			1997	2,338		15	156	156	858	30
31	Painting			1997	5,792		15	386	386	2,123	31
32	Landscaping			1997	6,430		15	429	429	2,359	32
33	Lockset, passage set			1997	9,104		15	607	607	3,338	33
34	Electrical service			1997	8,704		15	580	580	3,190	34
35	Ceiling Tiling			1997	3,762		15	251	251	1,380	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doors	1997	$ 8,000	$	15	$ 532	$ 532	$ 2,927	37
38	Remodeling of bathroom	1998	4,149		15	277	277	1,523	38
39	Remodeling of facility	1998	12,277		15	818	818	4,499	39
40	Painting	1998	2,541		15	169	169	930	40
41	Tiling	1998	2,205		15	147	147	809	41
42	Flooring	1998	27,771		15	1,851	1,851	10,181	42
43	Painting and Wallpaper	1998	2,912		15	194	194	1,067	43
44	Light Fixtures	1998	931		15	62	62	341	44
45	Cabinets/Drawers/Countertops	1998	1,401		15	93	93	512	45
46	Fence	1998	9,613		15	641	641	3,525	46
47	Piping	1998	168		15	11	11	61	47
48	Windows	1998	430		15	29	29	159	48
49	Security	1998	16,030		15	1,069	1,069	5,879	49
50	Architecture Services	1998	270		15	18	18	99	50
51	Signs	1998	3,500		15	233	233	1,282	51
52	Sidewalk	1998	720		15	48	48	264	52
53	Awning	1998	4,937		15	369	369	1,641	53
54	Nurse Station Shelving	1998	541		15	36	36	162	54
55	Landscaping	1998	1,614		15	108	108	486	55
56	Carpeting	1998	1,715		15	114	114	513	56
57	Air Conditioner Enclosures	1998	1,806		15	120	120	540	57
58	Sidewalk	1998	3,621		15	242	242	1,089	58
59	Beauty Shop Renovation	1998	623		15	42	42	189	59
60	Panic Bar	1998	279		15	19	19	85	60
61	Fountain	1998	290		15	20	20	90	61
62	Alarm Door Controller	1998	325		15	22	22	99	62
63	Light & related renovation	1998	963		15	64	64	288	63
64	Landscaping	1998	3,447		15	230	230	1,035	64
65	Grab bar, sink	1998	401		15	27	27	121	65
66	Annunciator @ nursing station	1999	2,500		15	167	167	751	66
67	Ceiling Tiles	1999	416		15	28	28	126	67
68	Drywall renovation	1999	1,930		15	129	129	580	68
69	Lavatory	1999	300		15	20	20	90	69
70	TOTAL (lines 4 thru 69)		$ 2,441,618	$		$ 78,135	$ 78,135	$ 607,216	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,441,618	$		$ 78,135	$ 78,135	$ 607,216	1
2	Lavatory	1999	324		15	22	22	99	2
3	Lighting	1999	983		15	66	66	297	3
4	Kitchen cabinets	1999	1,291	86	15	86		387	4
5	Asphalt resurfacing	1999	10,259		15	684	684	3,078	5
6	Door frames & accessories	1999	1,238	83	15	83		291	6
7	Insinkerator	1999	962	64	15	64		224	7
8	Painting and remodeling	2000	13,699		15	913	913	3,196	8
9	Hot water line	2000	2,569	171	15	171		343	9
10	Laundry room remodeling	2000	1,400	93	15	93		187	10
11	Moulding	2001	773	51	15	51		128	11
12	Moulding	2001	631	42	15	42		105	12
13	A/C condensor	2001	1,445	96	15	96		240	13
14	Labor for building improvements	2000	23,139		15	1,543	1,543	4,629	14
15	Water Heater	2002	2,739	183	15	183		274	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,503,070	$ 869		$ 82,232	$ 81,363	$ 620,694	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 459,984	$ 5,382	$ 46,577	$ 41,195	5-10 years	$ 323,176	71
72	Current Year Purchases	10,195	906	906		5-10 years	906	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 470,179	$ 6,288	$ 47,483	$ 41,195		$ 324,082	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1997 Ford E150***	1997	$ 21,597	$	$	$	3	$ 21,597	76
77	Resident transportation	1995 Chevy Corsica***	2002	1,522	507	507		3	761	77
78	Resident transportation	1997 Ford Taurus***	2002	3,044	1,016	1,016		3	1,523	78
79	Resident transportation	1992 Chevy Van***	2002	2,801	933	933		3	1,400	79
80	TOTALS			$ 28,964	$ 2,456	$ 2,456	$		$ 25,281	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,112,213	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,613	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,171	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 122,558	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 970,057	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,525 Description: Copier-$2,420; Paving Breaker-$105
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 38,925	$ 38,925	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,502)	215,546	215,546	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,716	20,716	6
7	Other Prepaid Expenses	7,361	7,361	7
8	Accounts Receivable (owners or related parties)	244,049	244,049	8
9	Other(specify): Prepaid Deposit	7,642	7,642	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 534,239	$ 534,239	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		110,000	13
14	Buildings, at Historical Cost		2,032,485	14
15	Leasehold Improvements, at Historical Cost	13,047	470,585	15
16	Equipment, at Historical Cost	57,622	499,143	16
17	Accumulated Depreciation (book methods)	(33,447)	(970,057)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in subsidiary	2,485	2,485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,707	$ 2,144,641	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 573,946	$ 2,678,880	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,798	$ 79,798	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,380	6,380	29
30	Accrued Salaries Payable	66,347	66,347	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,191,000	1,111,040	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,343,525	$ 1,263,565	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,236,431	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,236,431	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,343,525	$ 4,499,996	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,769,579)	$ (1,821,116)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 573,946	$ 2,678,880	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Casey Care Center
Provider #0039800
June 30, 2003

Schedule 17A

XV. Balance Sheet

Line 36-Other	Operating	After Consolidation
Accrued Expense	7,826	7,826
Resident Credit Balances	35,525	35,525
Due to related party	1,007,805	1,007,805
Accrued Rent	1,079,960	
Accrued Participation Fees	28,779	28,779
Accrued Insurance	31,105	31,105
	2,191,000	1,111,040

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,311,809)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,311,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(347,337)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Certain expense allocations**		15
16	Other (describe) **added back in column 7**	(110,433)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (457,770)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,769,579)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,933,399	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,933,399	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,432	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,714	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,146	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	389	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 439	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See attached Schedule 19a	2,786	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,786	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,943,770	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	453,957	31
32	Health Care	974,672	32
33	General Administration	348,050	33
	B. Capital Expense		
34	Ownership	439,147	34
	C. Ancillary Expense		
35	Special Cost Centers	17,246	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,291,107	40
41	**Income before Income Taxes (line 30 minus line 40)****	(347,337)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (347,337)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Casey Care Center
Provider #0039800
June 30, 2003

Schedule 19A

XVII. Income Statement
Line 28: Settlement Income

Description	Amount
Vending Income	994
Miscellaneous Income	350
Forgiveness of Debt	1,442
Total	2,786

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,021	2,121	$ 40,496	$ 19.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,162	5,406	88,868	16.44	3
4	Licensed Practical Nurses	13,317	13,998	186,417	13.32	4
5	Nurse Aides & Orderlies	58,911	63,529	494,178	7.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,806	2,025	16,641	8.22	8
9	Activity Director					9
10	Activity Assistants	2,788	2,934	18,794	6.41	10
11	Social Service Workers	1,891	2,011	16,422	8.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,247	16,186	104,180	6.44	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,085	15,786	7.57	17
18	Housekeepers	11,479	12,341	74,292	6.02	18
19	Laundry	4,922	5,366	32,027	5.97	19
20	Administrator	1,904	2,024	48,299	23.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,048	2,168	20,615	9.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	730	766	4,867	6.35	31
32	Other Health Ca See Sch 20A	3,739	4,057	55,371	13.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,047	137,017	$ 1,217,253 *	$ 8.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	106	$ 5,166	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	654	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6	176	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	763	L11, C3	44
45	Social Service Consultant	14	763	L12, C3	45
46	Other(specify) Office Consultant	Monthly	3,248	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	$ 16,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center
Provider #0039800
June 30, 2003

Schedule 20A

Schedule XVIII - Staffing & Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Amount	Ave. Hourly Wage
Care Plan Coordinator	2,055	2,255	29,312	13.00
Resident Service Director	1,684	1,802	26,059	14.46
	3,739	4,057	55,371	13.65

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephen Hopkins	Administrator	0%	$ 48,299
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,299

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$ 123,000
Administrative Service Fees	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 123,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 1,245
Campbell, Black, Carnine,		
Hedin, Ballard & McDonald	Legal	296
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,541

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,970
Unemployment Compensation Insurance	9,943
FICA Taxes	93,169
Employee Health Insurance	16,316
Employee Meals	15,584
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,548
TOTAL (agree to Schedule V, line 22, col.8)	$ 187,530

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,688
Health Care Worker Background Check	1,169
(Indicate # of checks performed 167)	
Miscellaneous License & Fees	198
Miscellaneous Dues & Subscriptions	138
Expense Allocation	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,447

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	410
Seminar Expense	1,025
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,435

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center
Provider #0039800
June 30, 2002

Schedule 21C

XIX. Support Schedules
Section C. Professional Services

TOTAL (agree to Schedule V, line 19, column 3)			**1,541**
Caravilla Charitable Corporation:			
	Altschuler, Melvoin & Glasser LLP	Accounting	10,103
Caravilla Residential Centers, Inc.:			
	Altschuler, Melvoin & Glasser LLP	Accounting	15,490
	American Express Tax & Business Services	Accounting	894
	Lawrence Manson	Legal	4,165
Less: Nonallowable collection fees	Cambell, Black, Carnine, Hedin, Ballard, & McDonald	Legal	(296)
	Total adjustments & allocations		30,356
TOTAL (agree to Schedule V, line 19, column 8)			**31,897**

SEE ACCOUNTANTS' COMPILATION REPORT

Caravilla Residential Centers, Inc.
Legal Fees Allocation
June 30, 2003

Professional Fees:

Lawrence Manson	9,233
	9,233

Detailed legal invoice listing:

Lawrence Manson	2,120
Lawrence Manson	540
Lawrence Manson	980
Lawrence Manson	2,060
Lawrence Manson	2,740
Lawrence Manson	793
	9,233

	Mt. Vernon	Jeffersonian	Casey Care	Total
number of beds	64	65	106	235
allocation %	0.27	0.28	0.45	1
Lawrence Manson	2,515	2,554	4,165	9,233
	-	-	-	-
	2,515	2,554	4,165	9,233

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4						N/A							
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,397** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,584** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **81%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Casey Care Center** **11:24 AM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	111,475	equal to	111,475	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	286,115	equal to	286,115	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	132,171	equal to	132,171	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,525	equal to	2,525	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	176	equal to	176	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	453,957	equal to	453,957	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	974,672	equal to	974,672	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	348,050	equal to	348,050	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	439,147	equal to	439,147	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	17,246	equal to	17,246	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	58,035	equal to	58,035	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	814,826	equal to	886,838	-72,012	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	18,794	equal to	18,794	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	16,422	equal to	16,422	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	104,180	equal to	104,180	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	15,786	equal to	15,786	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	74,292	equal to	74,292	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	32,027	equal to	32,027	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	48,299	equal to	48,299	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	20,615	equal to	20,615	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,217,253	equal to	1,217,253	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,166	< or = to	5,166	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	654	< or = to	654	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	763	< or = to	2,513	-1,750	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	763	< or = to	763	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	48,299	equal to	48,299	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	123,000	equal to	123,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	1,541	equal to	1,541	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	187,530	equal to	187,530	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,447	equal to	4,447	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,435	equal to	1,435	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	58,035	equal to	58,035	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	15,584	< or = to	63,554	-47,970	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	15,584	equal to	15,584	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	140,363	equal to	140,363	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,242,811	equal to	3,242,811	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	110,000	equal to	110,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,503,070	equal to	2,503,070	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	499,143	equal to	499,143	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	970,057	equal to	970,057	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,769,579	equal to	-1,769,579	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-347,337	equal to	-347,337	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	573,946	equal to	573,946	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!!**		11/04/05	11:24:46 AM		
HSA Number	5	Name	Casey Care Center			
Cost report period	From:	07/01/02	To:	06/30/03	Base Number	330
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	38,690	Occupancy:	25,024	Pct. of occupancy:	64.68%	
Illinois Public Aid Support Rate		$				
Genl Services Salary/Wage:	226,285	Col 1, Line 8 ---Audit Adj:				
Genl Admin Salary/Wage	68,914	Col 1, Line 28 ---Audit Adj:				
Total Salary Wage	1,217,253	Col 1, Line 44 ---Audit Adj:				
Employee Benefits	187,530	Col 8, Line 22 ---Audit Adj:				
Total General Services:	438,373	Col 8, Line 8 ---Audit Adj:				
Total General Admin	506,527	Col 8, Line 28 ---Audit Adj:				

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$226,285
Divided by Total Wages (Column 1, Line 44	$1,217,253
General service wages as percent of total wages	18.5898%
Employee Benefits (Column 10, Line 22	$187,530
Allocation of Employee Benefits to General Services Costs	$34,861
Plus Total General Services (Column 10, Line 8	$438,373
New Total General Services Cost	$473,234

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$68,914
Divided by Total Wages (Column 1, Line 45	$1,217,253
General administration wages as a percent of total wages	5.6614%
Employee Benefits (Column 10, Line 22	$187,530
Allocation of Emplayee Benefits to General Admin. Cost	$10,617
Plus Total General Administration (Column 10, Line 2	$506,527
Minus Total Fringe (Column 10, Line 22	$187,530
New Total General Administration Cos	$329,614

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	31	divided by 60.8 =	0.509868421
Beginning Year + Ending Year =	205	multiplied by 6 =	1230
Sum of the three lines			1237.009868
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			330

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$473,234	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$473,234

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$329,614	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$329,614
3 Total Updated Support Costs (1 + 2		$802,848

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cost

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO	$28.00

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$802,848
Total Patient Days (Cost Report	25,024
Support Costs per Diem	$32.08

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	38,690
Multiplied by	0.93
	35,982
Minus total Patient Days	25,024
	10,958
One-third of difference	3,653
Plus Total Patient Day	25,024
Adjusted Occupancy	28,677
Total Support Costs (Step II, C, 3, above	$802,848
Divided by Adjusted Occupany	28677
Support Costs Per Diem	$28.00

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Diem	$28.00
Difference	$4.69
Multiply the Difference by	0.5
One-Half of the Difference	$2.35
Plus Support Costs Per Diem	$28.00
Support Rate if costs are between 35th and 75th percentile	30.35

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Diem	$28.00
Difference	$4.69
Multiply the Difference by	0.5
One-Half of the Difference	$2.35
Compare one-half the difference to the profit ceiling for your HSA in Table II and	2.63
Enter the Lower of the Two Amounts	$2.350
Plus Support Costs Per Diem	$28.00
Support Rate if support costs less than 35th percentile	$30.35

D. **YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above** **$30.35**

75th Percentile is	$32.69
35th Percentile is	$27.53

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED
TO THE COST REPORT!!!! 11/04/05 11:24:46 AM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Casey Care Center** ID: **0039800**

HSA No.: 5 Own or Rent? (O or R) o Own or Rent Beginning: 10/1/1994

IF RENTED, have facilities been continously rented
from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings
constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	106	Total Patient Days	25,024
Begin	**07/01/02**	Licensed Bed Days:	38,690	% Occupied	64.68%
End	**06/30/03**			Capital Days	35,982

1989 Property Tax COST: ________ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ________ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ________ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1975
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	2503070
2. Total licensed beds from cost report Page 2, Line 7, column 3	106
3. Line 1 divided by Line 2	$23,614
4. Regional construction inflator from Table 2	2.77
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	65410
C. Obtain the Uniform Building Value from Table 1	9415
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	65410
2. Uniform building value from Line C	9415
3. Add Lines 1 and 2	74825
4. Divide by 2 to obtain average	37413
5. Enter 120% of line C	11298
6. The blended value is the lesser of Line 4 or Line 5	11298
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	33.3274
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	3.04
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	5.54
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	35,982
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	1.03753
5. Equals: Updated Property Tax Cost	0

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	25,024
2. Total Licensed Bed Days * .93	35982
3. Capital Days (higher of Line 1 or Line 2)	35,982

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	5.54
2. Add Property Tax from Line J5	0
3. Total capital rate (add Lines 1 & 2)	5.54

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	70	2025900	141813000	12
2	2	98	6585	645330	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	95	2586	245670	12
7	7	95	715	67925	12
8	8	95	14366	1364770	12
9	9	96	20184	1937664	12
10	10	96	9560	917760	12
11	11	96	7939	762144	12
12	12	96	7408	711168	12
13	13	96	54022	5186112	12
14	14	97	4110	398670	12
15	15	97	3082	298954	12
16	16	97	6284	609548	12
17	17	97	10739	1041683	12
18	18	97	10489	1017433	12
19	19	97	7202	698594	12
20	20	97	10900	1057300	12
21	21	97	27483	2665851	12
22	22	97	13900	1348300	12
23	23	97	21742	2108974	12
24	24	97	1986	192642	12
25	25	97	700	67900	12
26	26	97	18980	1841060	12
27	27	97	2338	226786	12
28	28	97	5792	561824	12
29	29	97	6430	623710	12
30	30	97	9104	883088	12
31	31	97	8704	844288	12
32	32	97	3762	364914	12
33	33	0	0	0	12
34	34	97	8000	776000	12A
35	35	98	4149	406602	12A
36	36	98	12277	1203146	12A
37	37	98	2541	249018	12A
38	38	98	2205	216090	12A
39	39	98	27771	2721558	12A
40	40	98	2912	285376	12A
41	41	98	931	91238	12A
42	42	98	1401	137298	12A
43	43	98	9613	942074	12A
44	44	98	168	16464	12A
45	45	98	430	42140	12A
46	46	98	16030	1570940	12A
47	47	98	270	26460	12A
48	48	98	3500	343000	12A
49	49	98	720	70560	12A
50	50	98	4937	483826	12A
51	51	98	541	53018	12A
52	52	98	1614	158172	12A
53	53	98	1715	168070	12A
54	54	98	1806	176988	12A
55	55	98	3621	354858	12A
56	56	98	623	61054	12A
57	57	98	279	27342	12A
58	58	98	290	28420	12A
59	59	98	325	31850	12A
60	60	98	963	94374	12A
61	61	98	3447	337806	12A
62	62	98	401	39298	12A
63	63	99	2500	247500	12A
64	64	99	416	41184	12A
65	65	99	1930	191070	12A
66	66	99	300	29700	12A
67	67	99	324	32076	12B
68	68	99	983	97317	12B
69	69	99	1291	127809	12B
70	70	99	10259	1015641	12B
71	71	99	1238	122562	12B
72	72	99	962	95238	12B
73	73	100	13699	1369900	12B
74	74	100	2569	256900	12B
75	75	100	1400	140000	12B
76	76	101	773	78073	12B
77	77	101	631	63731	12B
78	78	101	1445	145945	12B
79	79	100	23139	2313900	12B
80	80	102	2739	279378	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
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119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
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146	0	0	0	12D
147	0	0	0	12D
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149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

188264026 2503070 75.21324853

Base Year = 1975

TABLE 1 2

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 2

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	104,180	9,723	5,166	119,069	0	119,069	0	119,069
2. Food Purchase	0	103,638	0	103,638	0	103,638	-15,584	88,054
3. Housekeeping	74,292	11,408	0	85,700	0	85,700	0	85,700
4. Laundry	32,027	9,595	0	41,622	0	41,622	0	41,622
5. Heat and Other Utilities	0	0	61,315	61,315	0	61,315	0	61,315
6. Maintenance	15,786	0	26,827	42,613	0	42,613	0	42,613
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	226,285	134,364	93,308	453,957	0	453,957	-15,584	438,373
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	886,838	36,374	654	923,866	0	923,866	50	923,916
10a. Therapy	0	0	176	176	0	176	0	176
11. Activities	18,794	5,342	2,513	26,649	0	26,649	0	26,649
12. Social Services	16,422	138	763	17,323	0	17,323	0	17,323
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	658	658	0	658	0	658
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	922,054	41,854	10,764	974,672	0	974,672	50	974,722
17. Administrative	48,299	0	123,000	171,299	0	171,299	0	171,299
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,541	1,541	0	1,541	30,356	31,897
20. Fees, Subscriptions & Promotion	0	0	4,384	4,384	0	4,384	63	4,447
21. Clerical & General Office	20,615	3,695	21,294	45,604	0	45,604	3,423	49,027
22. Employee Benefits & Payroll	0	0	123,976	123,976	0	123,976	63,554	187,530
23. Inservice Training & Education	0	0	187	187	0	187	0	187
24. Travel and Seminar	0	0	869	869	0	869	566	1,435
25. Other Admin. Staff Trans	0	0	148	148	0	148	0	148
26. Insurance-Prop.Liab.Malpractice	0	0	42	42	0	42	60,515	60,557
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	68,914	3,695	275,441	348,050	0	348,050	158,477	506,527
29. Total General Administrative	1,217,253	179,913	379,513	1,776,679	0	1,776,679	142,943	1,919,622
30. Depreciation	0	0	9,613	9,613	0	9,613	122,558	132,171
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	2,107	2,107	0	2,107	284,008	286,115
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	424,902	424,902	0	424,902	-424,902	0
35. Rent - Equipment & Vehicles	0	0	2,525	2,525	0	2,525	0	2,525
36. Other (specify):*	0	0	0	0	0	0	4,039	4,039
37. Total Ownership	0	0	439,147	439,147	0	439,147	-14,297	424,850
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	75	75	0	75	0	75
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	58,035	58,035	0	58,035	0	58,035
43. Other (specify):*	0	0	17,171	17,171	0	17,171	-17,171	0
44. Total Special Cost Ce	0	0	75,281	75,281	0	75,281	-17,171	58,110
45. Grand Total	1,217,253	179,913	893,941	2,291,107	0	2,291,107	111,475	2,402,582

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	38,925	38,925
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	215,546	215,546
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	20,716	20,716
7. Other Prepaid Expenses	7,361	7,361
8. Accounts Receivable-Owner/Related Party	244,049	244,049
9. Other (specify):	7,642	7,642
10. Total current assets	534,239	534,239
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	110,000
14. Buildings, at Historical Cost	0	2,032,485
15. Leasehold Improvements, Historical Cost	13,047	470,585
16. Equipment, at Historical Cost	57,622	499,143
17. Accumulated Depreciation (book methods)	-33,447	-970,057
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	2,485	2,485
24. Total Long-Term Assets	39,707	2,144,641
25. Total Assets	573,946	2,678,880
CURRENT LIABILITIES		
26. Accounts Payable	79,798	79,798
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	6,380	6,380
30. Accrued Salaries Payable	66,347	66,347
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,191,000	1,111,040
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,343,525	1,263,565
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	3,236,431
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	3,236,431
46.Total Liabilities	2,343,525	4,499,996
47.Total Equity	-1,769,579	-1,821,116
48.Total Liabilities and Equity	573,946	2,678,880

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,933,399
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,933,399
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,432
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	3,714
22. Laundry	0
Subtotal - Other Operating Revenue	7,146
24. Contributions	50
25. Interest and Other Investments Income	389
Subtotal - Non-Operating Revenue	439
27. Other Revenue (specify):	0
28. Other Revenue (specify):	2,786
Subtotal - Other Revenue	2,786
30. Total Revenue	1,943,770
31. General Services	453,957
32. Health Care	974,672
33. General Administration	348,050
34. Ownership	439,147
35. Special Cost Centers	17,246
35. Provider Participation Fee	58,035
37. Other	0
40. Total Expenses	2,291,107
41. Income Before Income Taxes	-347,337
42. Income Taxes	0
43. Net Income or Loss for the Year	-347,337
43. Net Income or Loss for the Year	-347,337

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23	Provider Participation fee is linked from page 4